THE

LOUISVILLE MEDICAL NEWS.

"NEC TENUI PENNÂ."

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Original.

LECTURES ON FRACTURES.

Delivered in the Post-Graduate Course of the Medical Department of the University of Louisville. Session of 1883.

BY L. S. M'MURTRY, A.M., M.D.

II. GENERAL CONSIDERATIONS.

Gentlemen: The facts presented at the last lecture relative to the repair of fractured bones show that a number of days must elapse after the injury before the reparative process is actively instituted. Nevertheless it is the unanimous teaching of surgeons every where that the treatment of a fracture should begin immediately after the accident which has caused it. Under proper treatment, immediately begun, further injury to the soft parts is avoided and swelling is limited. Indeed swelling, when present, is best treated by the proper fracture dressing. Before the reduction of the fracture, as well as afterward, every disturbance of the fragments adds to the injury. Hence temporary dressings and frequent removal of the patient are to be avoided, if possible.

The first step in the treatment of fracture is *reduction*, meaning the bringing of the fragments into proper apposition. As has been already stated, the most potent cause of displacement is muscular action, and hence this contraction of the muscles is the principal obstacle to the reduction of fractures. This can be overcome in several ways. When the fragments are unlocked and brought down, the co-ordinating power of the muscles tends to bring about a proper adjustment. This is always to be accomplished in simple fractures without violence. The muscles can usually be relaxed by position, and when the reduction is prevented by muscular spasm this can always be overcome by an anesthetic. The muscles being relaxed, the reduction is accomplished by extension, counter-extension, and coaptation. A gentle, steady pull is usually all that is necessary, in fracture of the shaft of a bone, to throw the fragments into apposition. The action of the muscles, to which was due the deformity and the difficulty of reduction, now tends to restore the shape of the limb and the maintenance of reduction. When angular displacement alone exists, as in incomplete fractures, lateral pressure and counter-pressure are the means of reduction. In complete fractures of the shaft rotation is often a part of the process of reduction. In effecting reduction it is important to remember that not only is the length of the limb to be restored, but also its natural contour must not be destroyed by making it too straight. In impacted fractures, particularly those in the vicinity of the wrist, considerable force is often necessary to unlock the fragments; but this is the only form of fracture in which the employment of forcible means is admissible. The most perfect apposition of the fragments and the most satisfactory dressing of a fracture can be had when the patient is under the influence of an anesthetic. Since the introduction of anesthetics the greatest obstacles to this initial step in the treatment of fractures have been eliminated.

The remaining indication for the treatment of fractures after reduction is the retention of the fragments in apposition, which we may appropriately term *immobilization*. This is the object and purpose of all dressings for fractured bones. To preserve the fragments in a state of immobilization is very difficult in many cases during the first few days, on account of the spasmodic movement of the muscles of the injured part. Since no material progress toward union of the fragments obtains during the first ten days, this trouble does not affect the result

of our efforts. Immobilization is, as a rule, maintained by means of dressings of varied character and material. The prevention of displacement is only obtained by immobilization of the fractured surfaces, while at the same time the contiguous joints are secured. In some cases a serviceable apparatus in meeting these indications is one which continues the process utilized in reduction, and secures continuous extension with lateral support at the seat of fracture. In every instance complicated and elaborate apparatus should be avoided, while the objects of treatment are attained by the simplest means. Carved and manufactured splints are altogether useless, since they never fit accurately and are not adapted to the special indications of each case. In every case the choice of a dressing depends upon the nature and extent of the injury and the character of the displacement which is to be corrected. Bandages, pasteboard, dealboard, adhesive plaster, and the material for the plastic apparatus form all the essential appliances for the treatment of these injuries. Bandages for treating fractures should be applied with the utmost care and regularity, and it is better for them to be too loose than too tight. The old custom of applying a bandage immediately to the skin, to prevent muscular contraction and maintain reduction in fractures, is to be condemned under all circumstances. A bandage underneath the splints is not only altogether useless, but is dangerous in the extreme, on account of the risk of strangulation. So far as splints are concerned, it is an exceptionable injury which requires other than such as can be improvised by the practitioner. Wooden splints are made preferably of soft white wood, which can be easily shaped to the desired proportions. They are particularly adapted to coaptation and lateral support, and are always to be well padded with cotton. Pasteboard or binders' board, leather and gutta percha, felt, etc., owe their value as splints to the fact that they are soft and pliable after immersion in hot water, and may be molded to the shape of the limb, regaining, when dry, their accustomed firmness. Splints with similar adaptability may be made of layers of bandage saturated with starch, eggs and flour, liquid glass, and gypsum. The plaster-of-paris dressing is superior to all the other dressings of this class, for the following reasons: (1) It becomes so firm that it prevents displacement; (2) the rapidity with which it hardens maintains complete reduction and coaptation; (3) its porosity permits ventilation; and (4) its cheapness places it within the command of every one. Special apparatus composed of wire, steel, etc., is not necessary for the treatment of any variety of fracture. While extension and counter-extension are, as a rule, unnecessary to prevent shortening, yet there are special instances in which this method is serviceable. The principle of this method is, by moderate and persistent strain to overcome the muscles which cause displacement. Its best services are to be had in the treatment of fractures of the shaft of the femur. A strong band of mole-skin adhesive plaster, a small wooden block, with weight and pulley, all arranged after the method of Gurdon Buck, constitute the best method of applying constant extension. This plan of treating fractures of the thigh is not growing in favor, and it is not a great risk to predict that the plastic dressing will ere long supersede it. Regularity of pressure in all forms of dressings is of the utmost importance. For padding splints, and for padding the limbs when the plastic dressing is applied, cotton is preferable to all other material. It should be of the best quality of "batting," and the layers should be unbroken. Attention to these details has much to do with the prevention of muscular spasm, and thereby excludes the necessity of extension and counter-extension.

After a fracture has been reduced at once after the injury, and the fragments rendered immobile by a fixed apparatus, there should be no interference with, or removal of, the dressing without absolute and sufficient cause. There may, of course, be special indications for departure from this rule, as when the fracture is associated with a deep bruise, or when the limb becomes very painful without apparent cause. Needless interference, however, is to be avoided. No class of surgical cases requires more constant vigilance on the part of the surgeon than is required in the treatment of the injuries under consideration.

Compound and complicated fractures present certain special indications of treatment, which will receive attention in our next lecture.

LOUISVILLE, KY.

LONDON HOSPITAL POVERTY.—The financial darkness at present surrounding our hospitals grows thicker and thicker.—*London Lancet.*

HYSTERIA COMPLICATING TYPHOID FEVER.

BY E. J. KEMPF, M.D.

On April 2, 1883, I was called to see Miss Maggie K., who was having a "spell," as the messenger expressed it. On my arrival I found the patient sitting up in bed, panting for breath, crying as if her heart would break, and seemingly in great distress. Two sympathizing friends were propping her up, one was bathing her face and hands with cold water, and a half dozen or so were standing around doing nothing. The patient did not look at me as I entered, but kept on with the performance. Quietly taking a seat and waiting a moment or two, I commenced questioning the patient concerning her troubles, and she immediately seemed to recover from her spell.

She tells me that she has been ailing for two or three weeks, with pains in her bones and chest, a feeling of weariness in her limbs, and a melancholic state of mind. At present she gets a spell of suffocation every few minutes. She complains of pains in the region of the stomach, which will gradually pass up to her throat and there form a lump that threatens to suffocate her. Pains would also appear in the region of her heart, and she became faint and had to pant for breath. She has headache at the top of her head. Her appetite is tolerably good, but she has a great deal of thirst. She is menstruating at the present time somewhat to excess. Her face is flushed, but her skin does not feel hot to the touch. Her bowels are loose; she has two or three fluid, pale ocher-colored, offensive stools a day. Pressure over the ovaries causes pain. She has no tympanites or pain in the right iliac region. Pressure over the stomach causes pain, and she also feels nauseated. She has an idea that there is a lump in her stomach that ought to be removed by purgatives.

The nurse tells me that the patient is very peevish and troublesome, and that she is not satisfied with any thing done for her. She complains that her family does not care for her, and that all wish she would die. Her sister is at the present time having puerperal mania. Their father had suffered from dementia, following idiopathic epilepsy. The patient has also been disappointed in a love affair, a discarded lover having threatened her life. The patient has otherwise been healthy, and has never suffered from any acute sickness.

I diagnosed the case as one of hysteria, due to nervous exhaustion of a system already predisposed to the disease. I ordered an emetic dose of ipecac, to be followed by large doses of fluid extract of valerian, and pressure over the ovaries. This treatment was, however, of no avail; the patient had one so-called spell after the other. Large doses of morphine were also given, which seemed to control the patient somewhat. Dr. Paul Kempf was called in consultation, and he concurred in the diagnosis and treatment.

The patient seemed to gradually get worse, and on the fourth day seemed really to be sick. Her lips were dry and parched, her teeth and tongue covered with sordes, and she had more headache. The other symptoms were about the same. Her pulse was 120, full and strong; the temperature was 104° F. in the evening. Thinking that there was malaria in the case, I gave her thirty grains of quinine in three doses. She was thoroughly chinchonized.

In the morning of the fifth day her temperature was 102°, and in the evening 104° F. From the character of the stools, the range of temperature, rate of pulse, and gastric irritation, I concluded that this was a case of typhoid fever, complicated by hysteria. It is a fact that acute diseases have a tendency to develop hysteria in patients so predisposed, and this was evidently such a case. This was certainly a triumph of the clinical thermometer, as a proper diagnosis and a proper treatment could not have been made of the case without its aid.

I gave the patient a twenty-grain dose of quinine every morning, twenty drops of *listerine* in a tablespoonful of water every four hours, a quarter of a grain of morphine every six or eight hours, and liquid diet. The diet consisted of beef-tea, chicken broth, milk, egg-nog, diluted whisky, and occasionally a little coffee.

On the eighth day of the sickness the patient became more reconciled and the spells disappeared. The lump in her throat and the pain on pressure over the stomach remained. The tongue was coated with a whitish fur, with a clean, red, dry center. Her temperature ranged from 100° to 102° in the morning to 102° to 104° in the evening. No tympanites and no pain in the abdomen. A slight headache, and flying pains in the back, chest, loins and limbs. The stools remained of a fluid, pale ocher-colored appearance, and of a sickly, offensive odor. She generally had from three to four

stools in the morning and one or two at night. This state of things remained about the same until the nineteenth day, when the patient became convalescent. Her diet was still restricted, and perfect rest both of body and mind was earnestly enjoined. No relapse took place, and the symptoms of hysteria disappeared except a little nervousness. She has since menstruated normally.

FERDINAND, IND.

Miscellany.

THE AMERICAN MEDICAL ASSOCIATION.—The Ohio & Mississippi Railroad offers to physicians attending the annual session of the American Medical Association at Cleveland reduced rates. Tickets will be sold at the offices of the O. & M. R. R. in Louisville and Cincinnati, and at all points on this road and its connections, for one fare going, and on presentation of the secretary's certificate a return ticket will be furnished at the low rate of one cent per mile. This road is first-class in every particular, and delegates taking this route will be carried safely, pleasantly, quickly, and courteously.

CLAIMS FOR PRIORITY IN OBSERVATION AND IN THE INSTRUCTION OF NEW METHODS OF TREATMENT.—The following, from the London Medical Press, we commend to our readers:

From time to time unseemly wrangles appear in the columns of our medical journals in connection with the claim to priority in bringing forward what is regarded as a new observation or a new method of treatment. That such should be the case is a matter of regret, and springs from the ungenerous side of our nature on the one hand, and a want of true largeness of spirit and of wisdom on the other. The one desires to belittle another's efforts, taking pride in displaying the extent of his own reading; the other should certainly not allow himself to be disturbed or put out by the fact that what to him is new has been known before. That such should be the case does not rob him of the credit of originality as far as he is concerned, since his conclusions are the result of original observation and thought on his own part, and to him are a fresh departure. Indeed, there is no reason why he should not welcome the proof that to others had occurred the same idea as to himself. That two men should arrive independently at certain conclusions is more or less evidence of the truth of those conclusions, or, at least, lends additional color to the likelihood of their being true, and in so doing tends to heighten the value of the observations made or conclusions arrived at. It is true that the longer we live the more clearly we find that those who have gone before us have been acute observers and close thinkers, fertile in therapeutic resource and careful in watching and recording the results of the remedies employed or the methods of treatment adopted by them in their medical and surgical management of the cases under their care.

Modifying the old adage, we may safely say that much that is true is not new, and much that is new is not true. *What is true*, and occurs to one man as the result of original observation and thought, may just as well occur to many; and the credit of the observation is just as great for all as for one, provided the work is original; *in that alone lies the credit.* There is good reason why old truths should be rediscovered as new ones. The opportunities and scope for the clinical study of disease is limited to the human body itself; therefore, the same problems which are presented to us now were presented in the days gone by to eyes and minds of highly cultivated men, and men who were thoroughly accustomed to the close observation of symptoms and the effects of remedies, since they were not acquainted with the various methods of physical examination that are now in every-day use and are looked upon as almost essential to the proper study and treatment of disease. The study of symptoms and of therapeutics and the knowledge of materia medica was almost greater in former days than it is at present. Many methods of treatment were initiated in those days which were sound in principle, but which were greatly abused in practice, and the effects of which were explained manifestly upon false grounds when brought to the test of advancing knowledge of physiology, in the study of which the last half century has seen such immense strides. Erroneous explanation of their *modus operandi* and abuse led to their disuse, and finally they sank into obscurity and practically became unknown. Here and there the fact that such methods had been in use is known; but the knowledge is confined to the few, and the practice is ignored by all till once more brought to light as the result of clinical observation and research by a new worker in the same field. Empirically the idea itself

has been found true, though wanting the additional force and support of scientific explanation that possibly increased knowledge of the laws of life may be able to give it.

Again, there is at all times a decided tendency to fashion in the treatment of diseases —*vide* the changes that have taken place in the various forms of stimulants recommended; now port, then sherry, then claret, then whisky and water, and so on through the whole range of hocks, burgundies, sparkling wines, beer, porter, brandy, gin, etc. Again, we recall to mind venesection, leeching, blistering, moxas, issues, the use of mercury, iodide of potassium, salicylates, and a host of remedies, every one of which is in itself most useful when used with proper discrimination and judgment, but which, each and all, have had their day of popularity, until brought into disrepute by being used without judgment, and, one may say, as a matter of routine in the treatment of cases for which they were altogether inapplicable. Even in the present day there is a wide and general abuse of the drug quinine, which is frequently prescribed by men who never take into consideration the fact that it is not always the most suitable tonic that can be given.

Of making books there is no end. Work succeeds work, edition follows edition; the works of the past are shoved almost out of existence by those of the present. Those who are busily engaged in active practice find it hard to keep abreast of the work of the present day, and would certainly find it almost impossible to dip deeply into the literature of the past, or possibly may not have even the opportunity for doing so. He would be indeed a remarkably clever man whose knowledge of the literature of his profession embraced all that has been written concerning disease and its treatment; it is not wonderful, then, that much ignorance of past methods of treatment should prevail, or that old ideas should be again brought forward as new truths by those who may fairly claim to be original workers in the practice of their profession. All generous minds will take pleasure in encouraging those who think they have discovered something new; while, among the latter, all who are truly wise and large-hearted will not grudge the credit due to those who have gone before, even if the idea in question has been only dimly shadowed forth rather than seen clearly, as it may be, in their own case.

To have the credit for original work is a laudable ambition enough, but at the same time it is not free from the taint of selfishness and self-seeking. The highest and most laudable form of ambition is to have at heart the true interests of the profession; to seek after truth for truth's own sake, and for the benefits it may confer upon suffering humanity; to put away small jealousies, and to encourage those who are earnestly making the most of their opportunities to relieve suffering and cure disease; and to be careful at all times to promote union and kindly feeling among the members generally of our noble profession. The kind and encouraging word is as easy to give as the bitter criticism and sneer: it ought to be the earnest desire of all to give it when at all possible to do so. Unity and good feeling among the members of the profession will lead to increased respect, and an improved position in the eyes of the world at large. Dissension and bitterness have entirely opposite effect.

THE CHOICE OF CLOTHES.—Much has lately been said and written to show that the demands of fashion should yield to the laws of physiology in matters of dress. Public attention has been prominently and frequently directed to certain well recognized reforms in garments, especially in those of women, which are of indisputable importance. (The British Medical Journal.)

The proposed improvements have mainly had reference to the shape and size of articles of apparel, and have chiefly been designed to prevent certain baneful constrictions and compressions, certain unscientific distributions of weight, and certain impediments to healthy movement and growth, which fashion has favored, but which are obviously in the truest sense unphysiological; but it must not be forgotten that, in dress intelligently adapted to its essential utilities, the materials of garments must be wisely chosen, and that the texture and color of clothes have as important bearings upon the health and happiness of their wearer as the mere "make" of his apparel. On these points, hygenic science has established certain definite and reliable conclusions. Whatever else may be said about clothes, their primary object is to protect against hurtful variations of cold and heat; all their other uses are either derived from, or are subsidary to, their essential purpose. If utility strictly rule, it is clear that the material, texture, thickness, and color of clothes must be governed in accordance with their bearing upon the protecting function of dress, and that these must be special-

ized in conformity with experience to meet the necessities of different climates and the requirements of various occupations. With regard to protection against extremes of simple cold, as distinguished from cold winds, wool is much superior, for equal thickness, to either cotton or linen. For protection against very extreme cold, besides wool, leather or waterproof clothing is very useful. Wool is especially adapted for underclothing; when protection against cold is particularly aimed at, all underclothing should be of this material. Against cold, cotton and linen, for equal thickness, are about equal in protective power. For protection against cold winds, leather and india-rubber, according to Dr. Parks, for equal thicknesses take the first rank; wool the second; cotton and linen taking the lowest places. For protection against extremes of heat, in the form of direct solar rays, the texture of clothes is practically immaterial; protection from this danger depends chiefly, if not entirely, upon color. White has the greatest protecting power, then gray, yellow, pink, blue, and black. For hot countries, white clothing is the best; next comes dress of a light gray or dust-colored shade, like the Indian "khakee." In the the shade, Dr. Parks found that the protecting effect of color against heat is not marked. Here the thickness and the conducting power of the material are the conditions which affect protection. With regard to the absorption of perspiration the hygroscopic properties of woolen fabrics are well known. The water penetrates into the woolen fibers themselves and distends them (hygroscopic water), and also insinuates itself between the fibers (water of interposition). In absorbent power for watery fluids, wool is greatly superior to either cotton or linen; and it has been found that the hygroscopic absorption of woolen fabrics, as compared with those of cotton and linen, is at least double in proportion to weight, and quadruple in proportion to surface. This observation applies to cotton fabrics made of cotton fibers as ordinarily prepared. Cotton fabrics made of fibers so dressed as to become absorbent, as in those made for surgical dressings, would probably equal, if they did not surpass, woolen materials in hygroscopic affinity. Among the subsidary functions of clothes are the effects of various dress material upon the absorption of odors, and in the protection against malarial emanations. These considerations respectively assume especial importance in some occupations and in some countries. Odors probably mark the diffusion of minute material particles. Their absorption by articles of apparel has been found to depend partly upon color and partly upon texture. Stark's observations show that the power of absorption of odors by dress fabrics, so far as color alone is concerned, is in the following order, black, blue, red, green, yellow, white. So far as the texture is concerned, the absorption of odors has been found to be in proportion to hygroscopic absorption. Woolen materials take up odors best. With regard to the protective influence of various dress materials against the effects of malarial emanations, the late Dr. Parkes wrote: "It has been supposed that wearing flannel next the skin lessens the risk of malaria. As it is generally supposed that the poison of malaria enters either by the lungs or stomach, it is difficult to see how protection to the skin can prevent its action, except indirectly, by preventing chill in persons who have already suffered from ague; but the very great authority of Andrew Combe, drawn from experience at Rome, is in favor of its having some influence; and it has been used on the west coast of Africa for this purpose with apparently good results."

THE SAP OF THE BIRCH.—An interesting observation, of much importance in the cause of vegetable physiology, has been communicated by Professor Attfield at a recent evening meeting of the Pharmaceutical Society. A slender white birch tree, with a stem which at the ground is only seven inches in diameter, having a height of thirty-nine feet, and before any foliage had developed, would appear to be able to draw from the ground about seven eighths of a gallon of fluid every twenty-four hours.—*Lancet.*

DR. RICHARDSON'S long expected work on subjects connected with preventive medicine is nearly ready for publication. The volume extends to about 1,000 pages, and includes a history of the phenomena, causes, and prevention of the common diseases affecting mankind. It will be entitled "The Field of Disease."

Dr. J. M. TONER.—The joint committee of the Congressional Library has ordered a bust in marble of this distinguished physician to be placed in the library. This is in recognition of the donation to the library of his extensive and valuable collection of medcal and historical works. The bust will be executed by J. Q. A. Ward, the well-known sculptor of New York.

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LUNSFORD P. YANDELL, M.D., - - }
L. S. McMURTRY, A.M., M.D., - - - } Editors.

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A FINAL WORD ON THE NEW YORK CODE QUARREL.

At the last meeting of the New York State Medical Society, unfortunately, the loyalists were in a minority and were outvoted. The rebels, regardless of the earnest protest of Flint and Sayre and a host of honored veterans who are for upholding and obeying the Code of Ethics of the American Medical Association, to which they have sworn allegiance until it is legally repealed, by temporary might carried the day. Then the loyal journals every where deprecated and deplored the manners and methods of the rebels.

The other day, the loyalists, by perfectly legitimate and strict parliamentary management, triumphed in the New York Academy of Medicine. And lo, now comes from the outgeneraled rebels a weeping and a wailing and a gnashing of teeth; a flood of bitter, abusive and violent denunciation; a whine and a snarl and a howl; a cowardly cry that it is cruel and unkind and unchristian and unscientific and ungentle and unesthetic, and all that sort of rubbish, to resort to such methods in medical bodies. This is all bosh, all rot, all baby talk! War is no child's play; it means fighting, and fighting means wounding and killing, and thin-skinned, tender-footed, soft-hearted people who are afraid of getting hurt should never go to war.

The American profession under the old code was moving on nobly in its line of duty, honoring itself and the nation by its honest work and worthy deeds, and making itself an example to the profession in other lands. The good and true soldiers of the army of medicine, the raw recruits as well as the veterans in all the lines of the service, were content to march patiently on, feeling that duty demanded allegiance to the old code till it was abrogated.

But content and quiet seem incompatible with the power of action. The great God's first children were not satisfied with the peace and plenty of Eden. Even the angels were not restful in their brilliant and indolent abode. Therefore it is not singular that lesser creatures in our little world should be guilty of folly.

Impelled by hunger or greed, or a thoughtless, brainless, lawless ambition, a lot of New York specialists, joined by a limited number of consulting physicians and some general practitioners, resolved to repudiate the code, to defy the great regular army of American medicine, and, assuming the role of a new Salvation Army, took, in effect, for their motto, "Do as you please," and for their code, "What is expedient is right, what pays is proper."

Such a course is stupidly wrong; such a policy is shameful.

The old code is not perfect; no code or creed ever is or will be. Our code is susceptible of vast improvement, but until the American Medical Association, the supreme medical power of the country, annuls or alters it the code must be obeyed. Its enforcement must be urged to the uttermost power of this body, and all minor associations are in honor bound to do all in their power to uphold the parent association.

In this connection a personal allusion may be pardoned, since one of New York's leading lights has seen fit to apply to one of his peers language most intemperate and unparliamentary, not to say rude and coarse. The Flints, Austin sr. and jr., seem to be singled out as the chief objects of attack

by the malevolent malcontents, who seek to overthrow the code and to assume the dictatorship of the medical profession of America. Austin Flint, jr., barring Dr. Gross and Dr. Austin Flint, sr., has done more than any living American to make our profession illustrious. A great man himself, and the son and grandson of great men, he needs no eulogy. The world knows and admires him. Austin Flint, sr., is not only America's, but, since Sir Thomas Watson's death, he is the world's most eminent physician. Blameless man and stainless gentleman, of peerless eminence in medicine, he should be elected, as we believe he will be, the next president of the American Medical Association. In making Dr. Flint its chief magistrate the association will honor itself more even than it will the recipient of the office, and at the same time will vindicate the honor and honesty of the profession by the election to its highest office of so prominent and faithful and steadfast a defender of its code.

We are for Austin Flint and the old code. For Dr. Flint forever, and for the code so long as it is the creed of the American Medical Association.

THE ANESTHETIC ART.

In a recent number of the British Medical Journal Mr. Roger Williams, F.R.C.S., records some instructive observations upon the administration of anesthetics. He gives a detailed account of six fatal cases, and in conclusion says: "I have observed that those who administer anesthetics too often, do so without any fixed principles to guide them. This is regretable, because, as many of these cases show, the fundamental laws of the anesthetic art can not be disregarded without entailing a deplorable sacrifice of life. I will here endeavor to state, in the briefest manner possible, the most important practical inferences from them. With regard to chloroform, then, subject to the attainment of the object in view, too much air can not be given during its administration; and, with regard to ether, too little air can not be given during its administration. From this, it follows that a long time is required to induce anesthesia by chloroform; but to produce the same result with ether a short time is sufficient. Now, by a long time I mean about a quarter of an hour, and by a short time about five minutes. Surgeons are not unfrequently to blame is this respect. How often one has heard it said to the chloroformist, 'Be as quick as you can; I want to commence the operation in five minutes.' In my opinion, this is equivelent to saying, 'Kill at least one per cent of my patients.' Those kinds of inhalers are the best which most facilitate the fulfillment of these requirements. For giving choloroform, one with a wire frame work, having a diaphragm of flannel, or some similar material stretched over the top of it, on which to evaporate the anesthetic, but open at the sides, would be very good; but a piece of lint, or the corner of a towel, properly used, would do as well. A graduated drop-bottle is necessary in any case, as only a small quantity of chloroform should be poured on at a time, which requires to be frequently renewed. For the administration of ether, Ormsby's inhaler seems to me to be the best; it was designed to fulfill the requirements just mentioned, and I have found it to answer admirably. There is only one other point I will now mention, and that is the importance of watching the respirations during the process. To do so properly, of course the epigastrium must be uncovered. It is of much greater value than feeling the pulse, since, when the latter stops, there is, as a rule, an end of the patient. Mr. Lister has very ably insisted on this. However, I have found it generally neglected at King's College."

THE annual meeting of the American Surgical Association will be held in Cincinnati on May 31st, June 1st and 2d, under the presidency of Prof. S. D. Gross.

Medical Societies.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

The Pathological Society of Philadelphia met Thursday evening, April 12, 1883, with Dr. M. O'Hara in the chair. Dr. Guy Hinsdale presented three aneurisms and a specimen of fracture of the base of the skull.

CASE I. *Aneurism of the arch of the aorta.* Wm. G., a fireman, aged forty-four, was admitted to the Episcopal Hospital, September 16, 1881, suffering from pneumonia of the right side associated with signs of pleurisy. It was noticed at the time of his admission that there was a slight diastolic murmur heard at the aortic cartilage, and that no radial or ulnar pulse could be felt upon the left side. The pneumonia pursued its course till it ended in death, on the eleventh day after admission. Eighteen hours before death occurred, however, after an attack of severe pain along the course of the sciatic nerve, he suddenly became unconscious and his respiration puffing. His pupils were contracted and his left arm rigid. His pulse became at once fuller and stronger than it had been since admission, there being ninety-six beats per minute. Fifteen hours before death the right side of the face was paralyzed. The radial pulse was smaller on the right side than on the left. The right foot was cold, and the posterior labial pulse behind the internal malleolus was just perceptible. Respirations were forty per minute, and stertorous; sweat and urine profuse. Twelve hours before death, respirations fifty-seven, temperature 106.2°. The patient remained essentially in this condition until his death. At the *post-mortem* examination, upon opening the thoracic cavity, the base of the right lung was found in the second stage of pneumonia. There was hypostatic congestion of the left lung. But what at once threw light upon the later features of the case was the presence of an aneurism of the transverse portion of the arch of the aorta. The specimen shows a symmetrical dilatation of the vessel capable of recieving a large hen's egg. On examining the brain, clots, probably of embolic origin, were found in the right cerebral hemisphere, thus accounting for the paralysis which had been observed.

CASE II. *Aneurism of the common and external iliac arteries.* Johann B., a farmer, aged twenty-six, was admitted to the Episcopal Hospital, October 27, 1882. His previous health was good; he denied specific history, and his habits were good. He was able to work until one week previous to admission, when he began to have pain in the feet and legs, shooting up the body to the head. His skin was yellowish, his tongue coated; his urine did not contain albumen. There was edema of the feet, and it is worthy of note that this had occurred on the right side four months before admission. His spleen was apparently enlarged; his lungs presented nothing abnormal; systolic and diastolic murmurs could be distinctly heard all over the cardiac area, but most clearly at the right second cartilage, and transmitted over the left subclavian and carotid vessels. The heart was considerably hypertrophied.

Six weeks later the attacks of pain in the right thigh and side, to which he had been subject ever since admission, became more frequent and severe. The murmurs at the aortic valve were systolic and diastolic, low, soft, and confused. A distinct thrill was now felt; heart's impulse quick and trembling.

About one week before death a swelling occurred in the right parotid region, extending to the cheek and the lower jaw. Subsequently a discharge, thin and purulent, took place from the ear, and the patient became unable to protrude his tongue. The edema of the right leg returned and increased daily, extending up to the body, the whole leg being about three times the bulk of the other. The aneurism grew with great rapidity; the distension of the vessel and the overlying structures gave rise to the greatest pain. The patient was unable to lie down, and was always found in the sitting posture. The mind was clear up to the day of his death, which occurred two months after admission.

At the autopsy, upon opening the abdomen, the aneurism was found very prominent, occupying the right side of the abdominal cavity, extending from the concavity of the liver to Poupart's ligament, a distance of about nine inches. The aorta bifurcated at the upper border of the fourth lumbar vertebra, the tumor arising from the common iliac artery one inch from the aorta. Its whole anterior surface was covered by peritoneum. The right kidney was elevated, lying upon the tumor's upper surface, the ureter passing over the convexity of the tumor and to the inner side. The psoas muscle and crural nerves were displaced and stretched to the outer side of the aneurism. The femoral artery emerges from

the tumor one inch above the origin of the profunda. Upon opening the sac a second sac was found within. No rupture had taken place. The cavities of both sacs were found filled with clots in various stages of organization. The walls were leathery, and large flaps of organizing clots were found attached to them. There was also *post-mortem* coagulation. The line of the blood-current could be determined by the passage of a catheter. This was found, both from above and below, to skirt the inner side of the tumor, and to pass through a comparatively short channel in its interior. Three of the bodies of the lumbar vertebra were slightly eroded. The heart is hypertrophied, its weight fifteen ounces. The mitral valve is normal, but the aortic valve shows exuberant vegetations which impede its action and which are very friable. The specimen presented embraces the heart, the aorta, the aneurism with the right kidney upon its upper surface, the right femoral and the left iliac arteries.

CASE III. *Aneurism of the abdominal aorta and left common and external iliacs.* Mary K., aged thirty, was admitted to the Episcopal Hospital, August 26, 1882. Her mother died in confinement and her father of heart disease. She had had three children; her husband was a bar-tender, and had been treated for syphilis at a dispensary; but the patient herself denied specific history, nor were any evidences of it found. She had never been ill before. Seven months previously she had pains in her left groin; these pains extended to the abdomen, and about five months previous to admission she noticed a small tumor in the hypogastrium, which pulsated and became painful on pressure. Three months later her strength began to fail; she became delicate and lost flesh. For one month the tumor had been prominent. Pain then came on spontaneously at intervals, and she had back-ache. She became weak and took to her bed. Two weeks before admission the left leg and thigh became painful and felt benumbed, and motion grew difficult, and for a time was lost. Meanwhile the tumor increased. Upon admission she was weak. Her face showed anxiety and suffering, and had a haggard and pinched look. The organs of digestion were not interfered with. Her lungs and heart were normal. On the right side of the abdomen a tumor was felt, one inch above the umbilicus and extending from one to two and one half inches from the median line downward two inches. It was painful on pressure, pulsated distinctly, and over it a distinct systolic bruit could be heard. A distinct notch separated this from a large, hard mass in the left iliac fossa, indistinctly pulsating, immovable and not particularly painful on pressure. There was a faint bruit. In the left thigh there was insensibility to touch over the distribution of the anterior crural nerve, while pain in the left knee was often so great as to deprive her of sleep. The urine did not contain albumen. At the end of two weeks sensation was diminished on the left side as high as the edge of the ribs and in the whole of the lower extremity, excepting the first and second toes. It was impaired over the buttock. Edema of both legs occurred. The posterior tibial on the left side could scarcely be felt to pulsate.

September 13th the patient suddenly died. At the autopsy the abdomen was first opened. There was no blood in that cavity. Upon the left side, in the iliac fossa, there was a prominent tumor of the size of a cocoanut; over it lay the psoas muscle, which was spread out in the shape of a thin aponeurosis. The iliacus muscle was displaced. The psoas parvus was inserted in the tissue covering the tumor. A fusiform dilatation of the aorta was then noted. The diameter of the aneurism was three times the normal diameter of the aorta. Commencing from a point seven inches above the bifurcation, it extended downward nearly five inches. A second aneurism occupied the left iliac fossa involving the left common and external iliac arteries. It was about six inches in length and was filled with old, fibrous, laminated clots. The latter aneurism had opened posteriorly behind the peritoneum and against the iliac bone. There had evidently been ruptures previous to the one which finally caused the patient's death. There were found old as well as recruit clots outside the aneurismal walls. There was no erosion of the bones. The femoral artery was normal, and no atheroma or evidences of syphilis observed, although the woman had been exposed to infection from a syphilitic husband.

A CINCINNATI medical journal, in an editorial notice of the distinguished English physiologist, Professor W. B. Carpenter, expressed surprise that he should be a member of the Unitarian Church, as among his (the editor's) acquaintances of professors of that faith he knew no one who was not a homeopathist.

Correspondence.

NON SIMILIA SIMILIBUS CURANTUR.

Editors of Louisville Medical News:

I beg leave to offer the following explanation of the case reported by your correspondent, "E. R.," in the NEWS of May 12th, without in any way "recognizing homeopathy" or appealing to the absurd theory of *similia similibus curantur*.

We have only to admit that accident No. 1 produced an inequality between the hemispheres of the brain, which was proven by the strabismus, and was sufficient to produce inequality between the motor and sensory functions of the cerebrum.

Nothing is more common than to find, in consequence of pressure on either hemisphere by blood, pus, or exostosis, a variety of alterations in the intellectual and motor functions of the brain. If both hemispheres of the brain, however, be affected equally, the action, though weaker, will be more uniform and exact.

This was, in my opinion, the condition of "E. R.'s" patient after accident No. 2, behind right ear.

The second injury, having established an equilibrium between the hemispheres, restored one or more of the ocular nerves which had lain dormant on account of the damage produced by the first accident over the opposite hemisphere. A. S.

HOPKINSVILLE, May 14, 1883.

Editors Louisville Medical News:

In the "Miscellany" of your May 12th number you do a great injustice to the Woman's Medical College, of Chicago. The number graduated at the last commencement was twenty-three (23) instead of eight. Please correct, and oblige,

Truly yours, D. R. BROWN.

[We gladly make the correction, and apologize for the error. The Woman's Medical College has our best wishes. May each of its graduating classes excel in number and excellence its predecessor.—EDS.]

GALL-STONES. — Dr. John Barclay, of Leicester, England, highly recommends two or three drops of chloroform three or four times daily in any vehicle, persevered in for two periods of attack.

Selections.

THE TREATMENT OF PHTHISIS BY IODOFORM.—Dr. Dreschfeld has continued his observations since his first communication. (British Med. Journal.) The favorable opinion then formed has been further strengthened by the results obtained. Of sixty-four cases of confirmed phthisis, more or less advanced, and concerning, to a great extent, out-patients at the Manchester Infirmary, thirty-four cases only had been under treatment sufficiently long to be available for the purposes of this communication. Of these thirty-four cases, four were in so far advanced a condition that the iodoform was only borne in the form of inhalation, but gave no results. Two cases were complicated with amyloid disease, and here also the iodoform was useless. Of the remaining twenty-eight cases, ten showed either no improvement or only a temporary improvement (increase of weight, improvement of appetite, decrease of cough and expectoration); while the physical symptoms showed no alteration at first, but afterward the phthisical process gradually advanced, and associated again with loss of flesh, night-sweats, etc. Of the remaining eighteen cases, some showed slight but steady improvement, broken only temporarily by a fresh cold or some complication, such as gastric catarrh, pleurisy, etc.; while in six cases the improvement was most marked and beyond all expectation, the increase in weight amounting in one case to fourteen pounds, in another to ten pounds, and in a third to eight pounds, in one month. The physical symptoms also improved; the sputa, however, continued to contain tubercle bacilli. The iodoform treatment was also tried in six cases of incipient phthisis. Of these, two had only been under treatment a very short time. Of the four remaining cases, two showed no improvement; one was at once benefited, cough and expectoration entirely ceased, the apex catarrh disappeared, and the patient felt now perfectly well. In the second case (reported in the British Medical Journal) the treatment was equally successful—only, however, after having been continued for a longer time. There being an almost entire cessation of cough, it was difficult to obtain any sputa; one specimen, however, was obtained, and this was found free from bacilli, while before they were found abundantly. Two cases of laryngeal phthisis, treated both internally

and by inhalation, and also locally by the application of iodoform powder to the ulcers, gave satisfactory results; the ulcers cleared and became smaller, and the general condition improved. The iodoform was given in the form of pills (one grain of iodoform, two grains of croton chloral, one minim of creasote), and in the form of inhalation (twenty grains of iodoform, twenty minims of oil of eucalyptus or ten minims of creasote, and half an ounce each of rectified spirit and of ether). The inhaler used was one devised by Dr. W. Roberts, consisting simply of horse-hair matting, to the inner side of which was attached some flannel or cotton-wool; and on this the inhalation mixture was dropped. The cost of the inhaler was about three pence. Where the pills were badly borne (especially in women) the iodoform was added to cod-liver oil. In very young children, iodoform inunction, made with olive oil or vaseline, was to be recommended; while older children seemed to take iodoform, either as powders or in small pills, very well. The good effects of iodoform seemed to consist in the following: (1) Increase of weight; (2) increase of appetite; (3) diminution of cough and expectoration; (4) diminution or even total cessation of night-sweats; (5) the temperature was often a little lowered. No symptoms of iodoform intoxication had ever been seen. Several medical men who had tried the iodoform treatment had also obtained very satisfactory results.

Case of Muscular Atrophy.—Dr. Ross showed a case of what at first sight appeared to have been an example of progressive muscular atrophy. The case was that of a woman aged thirty, and the symptoms consisted chiefly of repeated attacks of paralysis, with wasting of the muscles of the forearm and hand, alternating with periods during which complete restoration of motor power had taken place. The patient stated that this was her seventh attack, and she was now rapidly recovering. The affected muscles manifested the typical "reaction of degeneration." Her sister was similarly affected for the first time a short time ago. She was under the care of Dr. Roberts, and subsequently of Dr. Dreschfeld, and had made a complete recovery. The occupation of both sisters was that of "cotton balling," which rendered necessary a very continuous use of the hands. Dr. Ross conjectured that this case must be classed along with the cases of muscular wasting described by Sir William Gull and others, in which a cavity was formed in the central part of the spinal cord, and which, from the nature of the lesion, have been named periependymal myelitis by Hallopeau.—*British Med. Journal.*

The Picric-acid Test for Albumen.—Dr. George Johnson writes, in the British Medical Journal:

It should always be borne in mind that, in testing for albumen, the *picric acid must be in excess.* A few drops of a saturated solution of picric acid in a highly albuminous specimen will form a coagulum which is quickly redissolved. When urine contains much albumen, it should be mixed with its own volume of the picric-acid solution; and, in testing a fresh specimen, it is better to begin by adding an equal volume of the test liquid.

One difference between the picric acid and nitric acid as tests is, that whereas an excess of nitric acid, especially when the urine is heated, will entirely redissolve the previously precipitated albumen, no excess of picric acid will redissolve the precipitate which it has once found in an albuminous solution. Picric-acid solution on the surface of the urine is applicable only for the detection of a minute trace of albumen. For this purpose, in my paper read at the Clinical Society, I advise that a column of urine four inches in height should be poured into a six-inch test-tube, and upon this one inch of the picric-acid solution. The result is that the upper layer of the urine is mixed with about its own volume of the test liquid; and if albumen is present, the stained portion of the urine is instantly rendered more or less opalescent, and thus contrasts with the unstained and transparent urine below. If the picric-acid solution were allowed to flow so gently on to the surface of the urine as merely to come in contact and not to become mixed with its upper portion, the albumen, if present, would not be detected, or it would be indicated only after an interval of some minutes, when the two liquids had become mixed by slow diffusion. There must be an actual mixture in about equal proportions, and not merely contact of the two liquids, to insure the action of the test.

The slight opalescence caused by the picric-acid solution in a sample of urine which contains a mere trace of albumen is always increased by the application of heat. So that, if the flame of a spirit-lamp be applied to the upper part of the opalescent column, this will become more opaque than the

lower part which had not been exposed to heat. I now invariably apply heat to a specimen of urine which has been rendered opaque, or more or less coagulated, by picric acid; my chief reason for this practice is to ascertain if peptones ever appear in the urine. In a paper published in the Journal, March 31st, p. 614, I have shown that, whereas the albuminous precipitate with picric acid is rendered more opaque and coherent by heat, the precipitate which picric acid gives with peptones is entirely redissolved by heat considerably below the boiling point. The microscope alone would serve to distinguish the precipitate caused by picric acid with peptones, with urates, and with albumen respectively.

The precipitate recently thrown down with artificially prepared peptone appears under the microscope quite homogenous and free from solid particles; but when the precipitate, having been dissolved by heat, reforms on cooling, it seems to consist of numerous very minute, apparently globular particles, in which the so called "Brunonian movement" is very active. The microscopic appearances of uric acid and urates are so well known as to need no description.

The precipitate produced by picric acid with albumen presents irregular clusters of granular material, which appear much larger and more opaque after the application of heat. According to my experience, a deposit of uric acid and urates is about as rare a result of adding picric acid to urine as a similar deposit caused by nitric acid; and hitherto I have met with no specimen of urine in which the presence of peptones has been indicated. A deposit thrown down by picric acid and redissolved by heat may pretty safely be assumed to consist of urates, but, in any case of doubt, the addition of Fehling's solution and the microscopic appearances will at once serve to distinguish between precipitated peptones and urates.

REPARATIVE SURGERY OF THE GENITAL TRACTS.—Dr. Mont A. Pallen writes, in the British Medical Journal:

All fallings of the uterus, from the slightest prolapse to the completest procidentia, involve more or less folding of the vagina; and, should the substructure, the perineal conjunction be absent, the process of vaginal folding ultimately becomes complete inversion. I formulate the following propositions:

1. Should there be perineal laceration, even if the uterine structure and circumuterine spaces be perfectly normal, the organ, sooner or later, necessarily sinks in the pelvis, most frequently in retroversion.

2. All perineal lacerations, from a simple submucous muscular sundering (of the *transversus perinei*, *sphincter* and *levatores ani* conjunctions) to a rent that extends into the bowel, necessarily beget vaginal dislocation, primarily as a slight, later as a complete rectocele, to be followed by a prolapse of the anterior wall, causing urethrocele and cystocele.

3. Urethrocele and cystocele seldom occur spontaneously; they ensue from pressure above (very rarely), or they follow from perineal sundering or laceration. I have never seen a case of cystocele, or even much urethrocele, that was not associated with some prolapse of the posterior vaginal wall.

4. All operative procedures for the *suspension of a prolapsed uterus must be directed mainly to the posterior vaginal wall*, because it arches upon the perineum below and the uterus above, serving chiefly as a column of support. The anterior vaginal wall, being straight and shorter, serves rather for the support of the urethra and bladder, and being adherent to the pubo-vesical spaces, it prevents the full bladder from rolling the uterus in retroversion.

5. Operations restoring the integrity of the perineum and posterior vaginal wall usually develop symmetrical correlations of the canal. In cases of complete procidentia, a perineum restored by plastic procedures which strengthen the recto-vaginal septum will eventuate in a permanent cure, a condition I have never seen in making operations confined strictly to the anterior vaginal wall.

These propositions assumed, I feel satisfied that very many successful issues of *perineo-vagino-plasty* prove that the theory upon which the operation was based is correct, viz., that the conjunction of the transversus perinei, sphincter ani, pubo-ischio-coccygeus, and levatores ani muscles (described, but never actually demonstrated as the perineum) is the true and correct foundation upon which the posterior vaginal wall rests, and that the *support rendered by the connective tissue in front of the rectum is but secondary, in consequence of the variable caliber of the bowel.* The anterior column of the vagina is straighter and shorter, and, as before said, mainly supports the bladder and urethra; but the posterior vaginal column, added to the masses of blood-vessels furrowing the perivaginal connective tissue, tends

to support the uterus; therefore, when the basement support of the vagina (perineum) gives way, it folds down upon itself and drags the uterus in retroversion. I would state, *en passant*, that I exceedingly doubt the efficacy of the so-called ligamentous support of the uterus, farther than the misnamed structures (broad ligaments) serve as vehicles for carrying masses of erectile tissue and blood-vessels; and that, in the healthy female, the uterine body maintains its normal plane, or it is lifted, or it is depressed therefrom, in consequence of plenitude or emptiness of these same blood-vessels. Furthermore, I am disposed to think that all misplacements, except from direct or mechanical causes, depend upon fracture or destruction of the connective tissue in the circumuterine spaces because of pathological changes in the blood-vessel.

NITRITE OF AMYL AND NITRO-GLYCERINE IN UREMIC ASTHMA.—Dr. A. Sheen writes, in the British Medical Journal:

Nitrite of amyl, acting, probably, through the vaso-motor nerves, relaxes the arterioles, and thus reduces blood-pressure. As it is very volatile, on the score of economy and convenience, I always carry some of Martindale's capsules in my bag, and these are very handy for immediate use. Nitro-glycerine is said to have much the same action as nitrite of amyl, and, according to Dr. Mahomed, its great superiority over amyl lies in its gradual and more lasting effect, and the more convenient manner of prescribing it, and it can be taken regularly two or three times a day, or oftener, one minim of a one-per-cent alcoholic solution being the usual commencing dose. It is also made up in chocolate tablets, each containing one hundredth part of a minim; but its action, when given in this form, is not so rapid as that of the alcoholic solution.

M. P., aged fifty-five, retired from business May 4, 1882. He had been ailing for two weeks, but had been about. He had noticed swelling of his legs toward night for two months, and his face had swollen occasionally for the last month. He had always been careless of his health, and if he got wet, an event which happened not infrequently, he would never change his clothes. He was taken suddenly ill in the evening while out walking, about a mile from home, and had to be taken home in a cab. On visiting him at 10 A.M. I found him sitting up in bed gasping for breath, countenance distressed, and of a sickly, pallid hue. Pulse feeble, temperature 98°, tongue pale and sodden, expectoration frothy with some little blood intermixed, moist *râles* over whole chest, back and front, urine abundant, clear, containing one fourth of albumen. At 2 P.M. I found his condition and posture unchanged; he could only speak a few words before he had to stop for breath. He inhaled three minims of nitrite of amyl (a capsule broken in a handkerchief). Within a few minutes his breath was easier, and he was able to recline in bed, for the first time since the attack came on, before I left the house. I then put him on nitro-glycerine, one hundredth of a minim thrice a day.

May 5th. He was lying easily in bed, breathing quietly, and expressing himself as feeling quite well; he said he was only waiting till I came before he got up. I cautioned him unavailingly that his life hung by a thread, and that he could only hope to continue it by the strictest obedience. On the sixth he still remained in the same improved condition. The next day he refused to take any more medicine, but promised to stay in the house, a promise which he did not keep. On the sixteenth he had another attack, and died quietly within thirty-six hours, the urine being loaded with albumen.

SPONTANEOUS FRACTURE OF THE TEETH. Mr. Alfred Coleman related, at a late meeting of the Odontological Society of Great Britain, the particulars of four cases which he had met with in the course of his practice, in which fracture or splitting of teeth had occurred without any apparent assignable cause, and referred to others recorded in the society's Transactions. It had been suggested that the splitting was due to accumulation of gases in the pulp-cavity; but he (Mr. Coleman) thought it was in some way connected with the calcification of the pulp, which he had found to be a constant concomitant, and he gave some reasons in support of his hypothesis. In the discussion which followed, all the speakers were of opinion that, in these cases of so-called spontaneous fracture of the teeth, the accident was always due to some form of mechanical violence, but that the real cause was overlooked or forgotten, owing to the fact that a considerable time might elapse before any symptoms appeared to call attention to the fracture. Cases were related by Messrs. Charles Tomes, Hutchinson, and Horn, in which there had been complete absence of symptoms for periods varying

from three months to nearly two years after the occurrence of such accidental fractures. Mr. Hutchinson also suggested that the calcification of the pulps, which was generally present, was due to irritation set up by the fracture, and was, therefore, a result of the accident, and not the cause of it.

RHEUMATISM AS A NEUROTIC DISEASE.—In the Medical News, Dr. Webster Smith communicates an interesting and rare example of a case of acute articular rheumatism occurring in a child two years and a half old. Commenting on the case, the editor observes that Dr. Smith very acutely says that the question of cerebro-spinal meningitis was considered in making up the diagnosis. The joint-changes which ensue in cases of meningitis have been described by Prof. Charcot and others. The late Prof. J. K. Mitchell advocated the neurotic origin of rheumatism, and his son, Dr. Weir Mitchell, has published many observations proving the dependence of joint-changes on spinal and nerve lesions. It is now, indeed, established that changes in the joints, which can not be distinguished from those of acute rheumatism, occur in cases of disease of and in lesions of the spinal cord, the membranes, and the nerve-trunks. This admitted, the case of Dr. Smith may be regarded from this point of view. The joint inflammation, the hyperpyrexia, the opisthotonus, and the muscular (choreic) spasms, the whole, concluding with coma, may be regarded as due to a common factor, meningitis. Whether one or the other view be taken, the case admirably illustrates the remarkable correspondence between acute rheumatism and certain spinal affections, and goes far to prove their community of origin. This admitted, acute rheumatism becomes not merely an inflammation of the fibrous tissues, but a neurotic affection.—*Medical Times and Gazette.*

FRACTURE OF THE SKULL, WITH CONJUGATE DEVIATION OF THE EYES.—Dr. George Thompson showed, at the Manchester Medical Society, March 7th (Brit. Med. Jour.), J. L., aged fourteen, who had suffered a simple depressed fracture of the skull in the left infero-postero-parietal area. The symptoms after injury were those characteristic of cerebral irritation. Consciousness was not completely recovered until six weeks after injury, when conjugate deviation of the eyes to the right was observed. This was so great as to cause both pupils to disappear behind the canthi, and made the boy practically blind. Both pupils reacted to light, and the right eye distinguished the light of a taper placed immediately in front of it. The facts seemed to Dr. Ross, who was consulted five months after the injury, to point to spasmodic deviation, and therefore to some source of irritation near the center for the movements of the eyes on the left side of the brain. The depression being near the supposed seat of irritation, trephining was suggested by Dr. Ross, and performed by Dr. Thompson. Two spicula of the inner table were found to be impinging on the brain-surface, and were removed. There was prompt improvement in the deviation after the operation, and in a few weeks it entirely disappeared.

TREATMENT OF FLOATING KIDNEY BY FIXATION.—We are informed that Dr. David Newman, of Glasgow, has performed for the first time in this country the operation of nephroraphy. The operation was performed in the following manner: The kidney was exposed by a vertical incision in the right loin, immediately external to the outer edge of the quadratus lumborum, and extending from the lowermost rib to the crest of the ilium; the capsule of the kidney was opened and stitched to the edges of the wound; and two catgut sutures were passed through the cortex of the kidney, the muscles, fascia, and skin, and secured externally by buttons. The patient suffered from severe symptoms, and was treated for several years without success; but since the operation the symptoms have entirely disappeared, and she has now almost recovered from the effects of the operation, which was performed three weeks ago.

TREATMENT OF STYES.—Louis FitzPatick, L.R.C.S., in the Lancet, says: The local application of tincture of iodine I have found, after many trials, to exert a well-marked influence in checking the growth of the stye. This is by far preferable to the nitrate of silver, which makes an unsightly mark, and often fails in its object. The early use of the iodine acts as a prompt abortive. To apply it the lids should be held apart by the thumb and index finger of the left hand (or a lid retractor, if such be at hand), while the iodine is painted over the inflamed papilla with a fine camel-hair pencil. The lids should not be allowed to come in contact until the part touched is dry. A few such applications in the twenty-four hours is sufficient, and I have

never seen a single instance in which, after this treatment has been resorted to, the stye continued to develop itself.

INCISION INTO AND DRAINAGE OF THE PERICARDIUM.—At the meeting of the Royal Medical and Chirurgical Society, on Tuesday evening last, Dr. Samuel West related a successful case of purulent pericarditis, treated by free incision and drainage. It is the first case which has been so treated in this country. The only other recent case on record is the one by Dr. Rosenstein, of Leiden, which was described in these pages two years ago. Dr. West's patient has fully recovered. There is no deformity of the chest, and nothing but a small scar remains to remind the patient of the narrow escape his life has had.—*Med. Times and Gazette.*

GENERAL VACCINE ERUPTION.—Dr. H. A. Martin (New York Medical Record) reports: A lady, aged thirty-six years, and her son, aged three years, were vaccinated on February 13, 1882, while an infant, seven months old, was not vaccinated because suffering from eczema capitis. The vaccination of the mother was successful. Sixteen days after, the infant became feverish, and showed in the region of the elbows red papules, which in the next three days extended over the whole body, but were especially numerous where the eczema was located. The eruption resembled variola, but all the efflorescences were round, surrounded by a red border, and ran exactly the course of vaccine pustules. From their contents, M. vaccinated a calf successfully, and from this, further, three children with good result.

Dr. Guéniot (*Progrès Médicale*) vaccinated a child five months old which had eczema of the head, shoulders, and breast. Four days after the vaccination large umbilicated papules appeared upon the eczematous surfaces, and by the eighth day reached the number of from two hundred and sixty to two hundred and eighty, and presented the picture of a variola confluens. They were accompanied with severe itching, and great loss of strength, but ran, however, the course of ordinary vaccine pustules.

Dr. S. Kolischer (*Deutsch. Med. Wochenschr.*) vaccinated a boy sixteen years old who had eczema faciei. Eight days later, the boy showed well-marked vaccine pustules upon the left arm where he was vaccinated, confluent pustules on the face, about ten pustules upon the flexor surface of each arm and leg, two on the pubis, and two on the dorsum of the penis. These followed the usual course, and left behind them the characteristic cicatrices. The general health of the child was undisturbed. The mother of the child, whose skin was perfectly intact, contracted one pustule upon the cheek, chin, and forearm.

Blot, Serebaullet, and E. Besniés have observed similar occurrences following vaccination of eczematous children, and although the result has never been fatal, it is a question whether under such circumstances it is not better to postpone the vaccination.—*American Journal of Obstetrics.*

BONE REMOVED FROM RECTUM.—Daniel Brogan, aged twenty-four, had suffered with diarrhea for three years and with passages of blood. The patient being put in Sims' position, and Sims' speculum introduced, a foreign body was discovered at the posterior portion of the rectum, within an inch of the anus. With a pair of forceps a small scale of bone, an inch in length, was extracted. *Dr. W. B. Canfield, in Maryland Medical Journal.*

KAIRINE.—The College and Clinical Record remarks that kairine is a recent product of the laboratory which promises to be a useful antipyretic, and, it is stated, is unaccompanied by the slightest tendency to produce local irritation. It is proposed as a substitute for chinoline, itself a substitute for quinine.

ARMY MEDICAL INTELLIGENCE.

OFFICIAL LIST of Changes of Stations and Duties of Officers of the Medical Department, U. S. A., from May 5, 1883, to May 12, 1883.

Bartholf, John H., Captain and assistant Surgeon, the extension of leave of absence, granted April 3, 1883, further extended four months. (Par. 8, S. O. 105, A. G. O. May 7, 1883.) *Billings, John S.*, Major and Surgeon, by direction of the Secretary of War, to represent the Medical Department of the Army at the annual meeting of the American Medical Association, to be held at Cleveland, O., June 5, 1883. (Par. 10, S. O. 105, A. G. O. May 7, 1883.) *Forwood, Wm. H.*, Major and Surgeon, by direction of the Secretary of War, to represent the Medical Department of the Army at the annual meeting of the American Medical Association, to be held at Cleveland, Ohio, June 5, 1883. (Par. 10, S. O. 105, A. G. O. May 7, 1883.) *Smith, Jos. R.*, Major and Surgeon, by direction of the Secretary of War, to represent the Medical Department of the Army at the annual meeting of the American Medical Association, to be held at Cleveland, Ohio, June 5, 1883. (Par. 10, S. O. 105, A. G. O. May 7, 1883.)